REASSESSMENT INFORMATION - ADOPTION ASSISTANCE PROGRAM

CHILD'S NAME
CHILD'S DATE OF BIRTH
CHILD'S AAP BENEFIT CASE NUMBER
COUNTY

DUE DATE (14 DAYS AFTER DATE MAILED)

The purpose of this form is to provide the responsible public agency with an update of the needs of the child for whom you are receiving an Adoption Assistance Program (AAP) benefit and Medi-Cal coverage. **Please complete, sign and date this form within two weeks,** attaching extra sheets if necessary, and send it to:

NAME OF RESPONSIBLE PUBLIC AGENCY
ADDRESS
TELEPHONE ( )

Check (✓) one of the following:

☐ We are legally responsible for the support of the child, and we are supporting the child.

☐ The above-named child has attained the age of 18 or 21.

☐ We are no longer legally responsible for the support of the above-named child.

☐ We are no longer supporting the above-named child.

Check (✔) one of the following

☐ 1. I/We no longer wish to receive an AAP benefit and/or Medi-Cal coverage for the above-named child. If the child's need change, I/we may contact the agency at that time.

☐ 2. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. The needs of the child have not changed to warrant a reduced level of payment. I/We request that the AAP benefit continue at the current level.

☐ 3. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I am/we are requesting an increase in the AAP benefit because the needs of the child have changed. I am/we are providing the agency the following information to assist the agency in determining whether or not increased assistance will be granted, and if so, in what amount. **(Please complete Section I.)**

☐ 4. I/We continue to need an AAP benefit and/or Medi-Cal coverage for the above named child. I/We request that the AAP benefit for the above named child be decreased to $_____because the needs of the child have changed. I/We understand if at anytime the child's needs change we may contact the agency to renegotiate the AAP benefit.

I/We understand that my/our child's next reassessment date will be on _____.
NEXT REASSESSMENT DATE

SECTION I

1. I am/We are requesting an increased AAP benefit based on the following needs of the child and circumstances of the family:

_____

_____

_____

_____

_____

_____

☐ I have attached written documentation to assist the adoption agency in making its determination.

2. HEALTH INSURANCE

Does the family have Health Insurance . . . . . ☐ YES ☐ NO

If Yes, name of Insurance Plan: _____

Is the child currently covered by this Insurance? . . . . . ☐ YES ☐ NO

If No, reason:_____

3. OTHER INFORMATION

a. Is the child a Regional Center client? . . . . . ☐ YES ☐ NO

If Yes, which Regional Center: _____

4. MONTHLY AMOUNT OF AAP BENEFIT CURRENTLY RECEIVED, IF ANY

☐ Total Monthly Amount: $ _____

Basic Rate: $ _____

Special Care Increment: $ _____

Wraparound: $ _____

Out-of-Home Placement: $ _____

Dual Agency Rate plus eligible Supplement Rate: $ _____

I/We certify through my/our signature(s) that the information provided in this Reassessment Information - Adoption Assistance Program form is true and correct to the best of my/our knowledge and belief. I/We make this statement under the penalty of perjury and understand that any willful concealment or misstatement of material fact in this request for adoption assistance may subject me/us to the penalties prescribed for perjury in the California Penal Code.

SIGNATURE OF ADOPTIVE PARENT	DATE	SIGNATURE OF ADOPTIVE PARENT	DATE

FAMILY ADDRESS

TELEPHONE

( )

EMAIL ADDRESS